

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012596</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/18/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>ELKHART DAY SURGERY, LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2746 OLD US HIGHWAY 20 WEST ELKHART, IN 46514</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for a preoccupancy survey of an Ambulatory Surgery Center.</p> <p>Facility Number: 012596</p> <p>Date: 5-18-2012</p> <p>Surveyor: Brian Montgomery Public Health Nurse Surveyor</p> <p>Elkhart Day Surgery, LLC meets the requirements for Ambulatory Surgery Center Licensure Rules 410 IAC 15.2 to admit and treat patients.</p> <p>QA: cloughlin 05/29/12</p>	S 000			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

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If continuation sheet 1 of 1